

Behavioral therapy for IBS

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Over the past 10 years considerable progress has been made in understanding the pathophysiology of IBS. IBS is now recognized as a multifactorial condition that involves disturbances of motility, visceral sensation and the central processing of noxious stimuli from the gut.¹ In addition, evidence shows that inflammation and genetic influences may also be important.¹ Despite these findings, psychological factors have always been the focus of considerable attention in the clinical setting, to the extent that IBS is often dismissed as a purely psychological condition. IBS is an excellent example of the medical profession's tendency to classify an illness as either organic or psychological, with the consequence that those conditions classified as psychological are sometimes regarded in a somewhat unsympathetic light. In 1977, Engel proposed the 'biopsychosocial' model of disease,² which seeks to explain the expression of an illness in terms of an integrated response to biological and psychosocial factors; IBS is a perfect example of an illness that fits this model.³

On the basis of our understanding of the pathophysiology of IBS, its medical management should first include an attempt to modify gastrointestinal motility, for example with antispasmodic, antidiarrheal or laxative drugs. The pharmacological modulation of visceral sensation is still in its infancy, but some evidence shows that antidepressants might have some utility in this respect.⁴ Clinically, little doubt remains that a low dose of a tricyclic antidepressant can be a very effective treatment for a significant proportion of patients with IBS, and some data support this view,⁵ however, how this benefit is mediated remains uncertain. Even if the mechanism of action of these drugs has a peripheral nervous system component, additional activity of antidepressants on the central nervous system seems likely. Virtually no data show whether a reduction in inflammation is of any use in the treatment of IBS, although one rationale for the use of probiotics in this

condition is that these agents may possess anti-inflammatory activity. Unfortunately, despite the use of conventional pharmacological approaches, the symptoms of many patients with IBS remain refractory to treatment and these individuals are often told that nothing more can be done for them.

Against this background of failed pharmacological management, psychologically oriented treatments, such as cognitive behavioral therapy (CBT), psychotherapy and hypnotherapy, have been trialed. Unfortunately, a true double-blind design is impossible to adopt in studies of these approaches and, as a consequence, systematic reviews on the subject are often highly critical of the methodology and conclude that insufficient evidence supports the use of these treatments. This situation is unfortunate and reviewers must recognize the constraints placed upon research in this field and accept that even if a trial does not exactly conform to double-blind standards, with careful design, studies can be robust enough to detect meaningful efficacy. These methodological difficulties should not dissuade investigators from attempting to accumulate evidence in this area; otherwise, potentially effective—and definitely very safe—approaches to the treatment of IBS are in danger of being overlooked.

Two major reviews of behavioral therapies for IBS were published in 2008.^{6,7} These articles agree that CBT, psychotherapy and hypnotherapy have all shown evidence of efficacy in clinical trials, and that possibly the best evidence supports the use of hypnotherapy to treat IBS. A trial that compares the effectiveness of all three treatments has never been performed and would be of considerable interest. Less research has been performed to investigate the durability of the benefits accrued by these behavioral therapies, although in some (but not all) studies that focused on this aspect, evidence of a sustained effect of CBT and especially hypnotherapy on improvement of symptoms has been documented for up to 5 years.⁸ The mechanisms by which the beneficial effects of these treatments

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Received 24 October 2008

Accepted 8 December 2008

Published online

3 February 2009

www.nature.com/clinicalpractice
doi:10.1038/ncpgasthep1361

are mediated remain uncertain, although some research has investigated the effects of hypnosis on the gastrointestinal system. A series of studies have shown that gastric acid secretion, gastric emptying, gastrocolonic response to food, orocecal transit, colonic motility, and the sensitivity of the gut all seem to be amenable to hypnotic modulation.⁹ These findings, coupled with the observation that hypnotherapy might have a role in the treatment of IBD,¹⁰ suggest that hypnosis might modify many of the putative pathophysiological events in IBS to which I have already alluded.

CBT is probably the most widely available behavioral therapy, and has the advantage of lacking the negative psychological connotations that are associated with hypnotherapy and psychotherapy, which can present a problem for many patients. Furthermore, psychotherapy is often associated with psychiatry, and hypnotherapy with stage hypnosis. In addition, the medical profession retains a considerable amount of skepticism and prejudice with regard to hypnosis, despite this therapy's reasonably good base of evidence. This skepticism probably arose because so many misconceptions persist about what this technique can or cannot achieve. Ultimately, however, which behavioral approach a patient is offered depends on local availability, rather than which treatment is necessarily most effective.

One of the most important concerns associated with all these behavioral approaches is that of the quality of the therapist. This issue is a particular problem in relation to hypnotherapy, because in the UK and in many other countries, anyone can set themselves up as a therapist, irrespective of whether they have had any training. Even for those organizations that do offer training and qualifications, no overall monitoring of standards is undertaken, which makes it impossible for the consumer to know exactly how and to what standard a therapist has been trained. Another issue that needs to be addressed is the lack of information on the content of any particular therapeutic package. Clinicians and patients have no idea whether sessions that different therapists offer for a treatment (e.g. CBT for IBS) are the same or completely different from each other. Obviously, these forms of treatment have to be flexible enough to meet the needs of the patient, but they must also offer enough uniformity that their delivery can be standardized as much as possible.

IBS can have a major effect on quality of life,¹¹ and its severity can even drive patients to suicide.¹² However, because drug regulators regard IBS as a trivial, nonlife-threatening illness and the hurdles for drug safety approval are so high, many pharmaceutical companies are deterred from developing new medications for this condition. Similar attitudes surround the funding of research into IBS, and, consequently, researchers can find it extremely difficult to gain support for trials of behavioral approaches to the treatment of this condition, especially for hypnotherapy, which has additional prejudices attached to it.

Policy and decision makers rightly demand high-quality research on the efficacy and safety of therapy for IBS, but hardly anyone is prepared to fund it. I hope that the recent interest taken in IBS¹³ by the UK National Institute for Health and Clinical Excellence and the establishment of the UK National Institute for Health Research, which focuses especially on patient-centered research, will help to change this situation.

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Competing interests

The author declared no competing interests.